

# ENROLLMENT APPLICATION

## 3 Easy Ways to Enroll

1. Complete the attached form and submit by mail.
2. Fax it to us directly: 1-410-308-7905
3. Call us: 1-800-732-5309 between 8:00 am-5:00 pm ET Monday-Friday for telephone assistance.



Mail application to:  
**MEDEX Insurance Services, Inc.**  
P.O. Box 19056  
Baltimore, Maryland 21284

**Notice:** Not available to Washington State residents.

## Applicant Information

First Name of Applicant \_\_\_\_\_ MI \_\_\_\_\_ Last Name of Applicant \_\_\_\_\_

Sex  Male  Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address/Fax Number \_\_\_\_\_

Home Country \_\_\_\_\_ Host Country \_\_\_\_\_

Name of Educational Institution in Host Country \_\_\_\_\_

## Premiums (Check one)

- U.S. Citizens Traveling Abroad**
- One month \$65.00
  - Four months \$120.00
  - Six months \$160.00
  - Nine months \$195.00
  - Annual \$225.00

- Foreign Nationals Traveling to the U.S.**
- Six months \$48.00
  - Annual \$60.00

Coverage Start Date \_\_\_\_\_ Coverage End Date \_\_\_\_\_

Primary Health Insurance Co. \_\_\_\_\_

Phone \_\_\_\_\_

Policy No. \_\_\_\_\_

## Person to be contacted in the event of an emergency

Full Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Relationship \_\_\_\_\_

## Payment Information

American Express  VISA  MasterCard  Check

Card Number \_\_\_\_\_

Card Security Number (optional) \_\_\_\_\_

Expiration Date (mm/yyyy) \_\_\_\_\_

Cardholder Name \_\_\_\_\_

Cardholder Signature \_\_\_\_\_

Please make checks payable to MEDEX Insurance Services. Remittances accepted in U.S. funds only.

As a condition precedent to FrontierMEDEX's obligation to provide services, the Participant will, upon request, assist FrontierMEDEX to (a) obtain relevant, personal medical information from the Participant's personal physicians; (b) collect proceeds due from Participant's insurers or other payors; and (c) obtain reimbursement of expenses paid by FrontierMEDEX on Participant's behalf for services not provided under the FrontierMEDEX program.

I hereby apply to purchase FrontierMEDEX's services under this program. I represent that the Participant meets the eligibility requirements of this program, and that the above statements and answers are complete and true to the best of my knowledge, information and belief. I also understand that these answers are the basis of the service contract between the Participant and FrontierMEDEX, and that any incorrect answers may void the contract. Enrollment will be effective upon receipt of payment and the completed application.

Credit card authorization is hereby granted.

Signature of Participant, Parent (if Participant is under 18), or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

FOR OFFICE USE Payment by: Check / M.O. / Credit Card

Check#	Amount
_____	_____